STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 01 B. WING	07/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVENUE INDIANAPOLIS, IN46227

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/25/11 Facility Number: 000537 Provider Number: 155409 AIM Number: 100267270 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and has battery operated smoke detection in all resident sleeping rooms. The facility	K0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	has a capacity of 81 and had a census of 47 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/28/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials are equipped with functioning self closing devices. This deficient practice could affect any resident, staff or visitor in the vicinity the housekeeping office. Findings include:	K0029	**K029–** It is the intent of the facility to ensure all doors serving hazardous areas such as storage rooms greater than 50 square feet in size that are used to store combustible materials are equipped with functioning self closing devices **1. ACTIONS TAKEN:** A. A properly functioning self closer has been installed on the housekeeping office door.	08/20/2011

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	Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 12:30 p.m. on 07/25/11, the housekeeping office measured 100 square feet and is used to store combustible housekeeping supplies in cardboard boxes and is equipped with a self closing device on the entry door but the arm on the self closing device was not in place. Based on interview at the time of observation, the Maintenance Director stated the housekeeping office is additionally used to store combustible housekeeping supplies and acknowledged the housekeeping office was greater than fifty square feet in size with an entry room door not equipped with a functioning self closing device. 3.1-19(b)		**2. OTHERS IDENTIFIED:** All residents would have the potential to be affected. All rooms over 50 square feet that are used to store combustible material have been checked and have proper functioning self closing devices in place. **3. SYSTEMS IN PLACE:** A. Self closing doors were added to preventative maintenance weekly program. **4. HOW MONITORED:** A. The Director of Maintenance/Designee will complete audit checks and report findings in monthly QA meetings B. The CEO/Designee will review all QA audits as completed in monthly QA meeting. C. The CEO/Designee will review monthly in QA meeting; and quarterly in QA meeting with the Medical Director. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is: August 20, 2011.**	

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K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was: 1) separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. 2) separated from a minimum distance of at least five feet from combustible materials. NFPA 99, 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Director during a tour of the	K0076	**K076–** It is the intent of the facility that all medical gas be stored and administered in areas protected in accordance with NFPA 99, Standards for Health Care Facilities. **1. ACTIONS TAKEN:** All respiratory supplies were removed from the oxygen and transfillling room on 07-27-11. A second layer of five eighths inch drywall was installed on 8-9-2011. **2. OTHERS IDENTIFIED:** A. All residents have the potential to be affected by this practice. **3. SYSTEMS IN PLACE:** A. There are no other oxygen and transfilling rooms in the facility. The oxygen room was added to the preventative maintenance weekly rounds to ensure it is maintained. **4. HOW MONITORED:** A. The Director of	08/20/2011

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	facility from 10:40 a.m. to 12:30 p.m. on 07/25/11, the oxygen storage and transfilling room contained one liquid oxygen canister and twenty eight oxygen storage tanks each containing 679 liters of oxygen. The oxygen storage and transfilling room had a ceiling with one layer of five eighths inch thick drywall. In addition, two six foot tall storage shelves containing boxes of respiratory supplies was being stored within five feet of the liquid oxygen canister and the twenty oxygen storage tanks. Based on interview at the time of observation, the Maintenance Director acknowledged the ceiling did not provide 1 hour fire resistive construction and combustible materials were stored within five feet of the liquid oxygen canister and the oxygen storage tanks. 3.1-19(b)		Maintenance/Designee will complete weekly audits and report findings in monthly QA meetings. B. The CEO/Designee will review all weekly audits results in monthly Q.A. meeting. C. The CEO/Designee will review monthly in QA meeting; and quarterly in QA meeting with the Medical Director. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is: August 20, 2011.**	

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was: 1) separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. 2) in an area having ceramic or concrete flooring. 3) in an area posted with signs indicating transferring of oxygen is occurring. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Director during a tour of the	K0143	**K143**– It is the intent of the facility to ensure that transferring of oxygen is completed in an area that is separated by a 1 hour fire resistive construction., with proper flooring and posted with proper signage. **1. ACTIONS TAKEN:** A second layer of five eights inch drywall was installed on 8-9-2011. Vinyl flooring was removed on 8-2-2011. Signage indicating transfilling was occurring was immediately placed on door. **2. OTHERS IDENTIFIED:** All residents would have the potential to be affected. **3. SYSTEMS IN PLACE:** A. There are no other oxygen and	08/20/2011

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	facility from 10:40 a.m. to 12:30 p.m. on 07/25/11, the oxygen storage and transfilling room contained one liquid oxygen canister, had a ceiling with one layer of five eighths inch thick drywall, had vinyl flooring and the area was not posted with signs indicating the transferring of oxygen occurs in the room. Based on interview at the time of observation, the Maintenance Director stated the facility started transfilling oxygen in the room within the last year and acknowledged the ceiling did not provide 1 hour fire resistive construction, the flooring was not ceramic or concrete and this area not posted with signs indicating the transferring of oxygen occurs in the room. 3.1-19(b)		transfilling rooms in the facility. The oxygen room was added to the preventative maintenance weekly rounds. **4. HOW MONITORED:** A. The Director of Maintenance/Designee will complete weekly audits and report findings in monthly QA meetings. B. The CEO/Designee will review all QA audits as completed in monthly QA meetings. C. The CEO/Designee will review monthly in QA meeting; and quarterly in QA meeting with the Medical Director. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.** **Our date of compliance is: August 20, 2011.**	